

Registration District No. **243**

Primary Registration District No. **5833**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural Newtonia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James Thomas Fulkerson M.D.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife Deliah Fulkerson

6. (c) Age of husband or wife if alive Dead years _____

7. Birth date of deceased February 23 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	9	18	hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Medical Doctor
II II

11. Industry or business _____

12. Name Thomas C. Fulkerson

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Martha Weems

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs R. S. Stephenson

(b) Address Stark City, Mo.

17. (a) Burial (b) Date thereof 12-11-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson, Missouri

18. (a) Signature of funeral director Wm. Maria Byne

(b) Address Wheaton, Mo.

19. (a) 12-30-48 (b) Alpha Dyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Stark City, Mo. R#
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11
year 1948 hour 3 minute _____ P. M.

21. I hereby certify that I attended the deceased from 12-11 10 AM 1948 to 12-11 5 PM 1948
that I last saw him alive on 12-11-1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury? _____

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 12/10/48

RECEIVED
District Health Officer No. *Walter E. Smith*
District File Number *149-4*
Date Filed *1-3-49*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Wm Morris Pogue*
Licensed Embalmer No. *3942A*
P. O. Address *Wheaton, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.